NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Disabled Children's Program Application

Name of Applicant	Date of Birth	Social Security Number

Parent/Guardian Name	Email Address
Address	**Mailing Address (if different)**

City	State	Zip Code	County

Home Phone	Cell Phone	Work Phone

School/Grade	Primary Care Physician
Health Insurance	**Physician Specialists**
Current Pay SSI? ☐ Yes ☐ No	SSI Eligible Diagnosis

Household Members (Please Print)	Relationship to Child
(Please use additional sheet, if needed)	

Please describe your child's disability related limitations:

Signature of Parent/Guardian	Signature Date

Send completed application to:
Medically Handicapped Children's Program, Department of Health & Human Services, PO Box 95026, Lincoln, NE, 68509-5026
Email: DHHS.MHCP@nebraska.gov